General

Guideline Title

Primary care interventions to support breastfeeding: U.S. Preventive Services Task Force recommendation statement.

Bibliographic Source(s)

U.S. Preventive Services Task Force. Primary care interventions to support breastfeeding: U.S. Preventive Services Task Force Recommendation Statement. JAMA. 2016 Oct 25;316(16):1688-93. [19 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force. Primary care interventions to promote breastfeeding: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med. 2008 Oct 21;149(8):560-4. [11 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the Levels of Certainty regarding Net Benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendation and Evidence

The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding. (B recommendation).

Clinical Considerations

Patient Population under Consideration

This recommendation applies to pregnant women, new mothers, and their infants and children. Interventions to support breastfeeding may also involve a woman's partner, other family members, and friends. This recommendation does not apply to circumstances in which there are contraindications to breastfeeding (e.g., certain maternal medical conditions or infant metabolic disorders, such as galactosemia). The USPSTF did not review evidence on interventions directed at breastfeeding of preterm infants (see Figure 2 in the original guideline document).

Interventions

Breastfeeding support can begin during pregnancy and continue through the early life of the child. Primary care clinicians can support women

before and after childbirth by providing interventions directly or through referral to help them make an informed choice about how to feed their infants and to be successful in their choice. Interventions include promoting the benefits of breastfeeding, providing practical advice and direct support on how to breastfeed, and providing psychological support. Interventions can be categorized as professional support, peer support, and formal education, although none of these categories are mutually exclusive, and interventions may be combined within and between categories.

Professional Support

Professional support is 1-on-1 counseling about breastfeeding provided by a health professional (medical, nursing, or allied professionals, including those providing lactation care). Some interventions include the provision of supplies, such as educational materials, nursing bras, and breast pumps. Professional support can include providing information about the benefits of breastfeeding, psychological support (encouraging the mother, providing reassurance, and discussing the mother's questions and problems), and direct support during breastfeeding observations (helping with the positioning of the infant and observing latching). Professional support may be delivered during pregnancy, the hospital stay, the postpartum period, or at multiple stages. It may be conducted in an office setting, in the hospital, through home visits, through telephone support, or any combination of these. Sessions generally last from 15 to 45 minutes, although some programs have used shorter or longer sessions. Most successful interventions include multiple sessions and are delivered at more than 1 point in time.

Peer Support

Similar to professional support, peer support provides women with 1-on-1 counseling about breastfeeding but is delivered by a layperson (generally a mother with successful breastfeeding experience and a background similar to that of the patient) who has received training in how to provide support. Like professional support, peer support may be delivered through a variety of stages, settings, methods, and durations.

Formal Education

Formal education interventions typically include a formalized program to convey general breastfeeding knowledge, most often in the prenatal period, although some may span time periods. Education is usually offered in group sessions and may include telephone support, electronic interventions, videos, and print materials. They are directed at mothers but may include other family members. Content generally focuses on the benefits of breastfeeding, practical breastfeeding skills (e.g., latching), and the management of common breastfeeding complications; these programs may also offer family members encouragement and advice on how to support the mother.

Useful Resources

The Centers for Disease Control and Prevention provides information on different breastfeeding intervention strategies, including program examples and resources. Another resource is the Surgeon General's "Call to Action to Support Breastfeeding."

Definitions

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read the "Clinical Considerations" section of the USPSTF Recommendation Statement (see the "Major Recommendations" field). If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Infant health/nutrition

Guideline Category

Counseling

Clinical Specialty

Family Practice

Internal Medicine

Nursing

Obstetrics and Gynecology

Pediatrics

Preventive Medicine

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Nurses

Physician Assistants

Physicians

Public Health Departments

Guideline Objective(s)

To update the 2008 U.S. Preventive Services Task Force (USPSTF) recommendation on primary care interventions to promote breastfeeding

Target Population

Pregnant women, new mothers, and their infants and children

Note: Interventions to support breastfeeding may also involve a woman's partner, other family members, and friends.

Interventions and Practices Considered

Interventions to promote and support breastfeeding during pregnancy, at delivery, and after birth:

- Professional support
- Peer support
- Formal education

Major Outcomes Considered

- Key Question 1: What are the effects of prenatal, peripartum, and postpartum individual- and health care system–level interventions to promote and support breastfeeding on short- and long-term child and maternal health outcomes?
    a. Does the effectiveness of breastfeeding interventions differ by the population subgroups based on age, race/ethnicity, and socioeconomic status?
    b. Are there intervention characteristics that influence the effectiveness of breastfeeding interventions?
- Key Question 2: What are the effects of prenatal, peripartum, and postpartum individual- and health care system–level interventions to promote and support breastfeeding on initiation, duration, and exclusivity of breastfeeding?
    a. Does the effectiveness of breastfeeding interventions differ by the population subgroups based on age, race/ethnicity, and socioeconomic status?
    b. Are there intervention characteristics that influence the effectiveness of breastfeeding interventions?
- Key Question 3: Are there adverse events associated with interventions to promote and support breastfeeding?

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Kaiser Permanente Research Affiliates Evidence-Based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Sources and Searches

Forty-one studies (in 42 articles) included in the 2008 review were re-evaluated, and the following databases were searched for new relevant English-language literature published between January 1, 2008, and September 25, 2015: MEDLINE, PubMED (for publisher-supplied records only), PsycINFO, CINAHL (Cumulative Index for Nursing and Allied Health Literature), and CENTRAL (Cochrane Central Register of Controlled Trials) (see the eMethods in the systematic review supplement). The database searches were supplemented by reviewing bibliographies from other relevant literature and from expert suggestions. ClinicalTrials.gov and the World Health Organization International Clinical Trials Registry Platform were searched for ongoing trials. Since October 2015, ongoing surveillance was conducted through article alerts and targeted searches of high-impact journals to identify major studies published in the interim that may affect the conclusions or understanding of the evidence and therefore the related USPSTF recommendation. The last surveillance was conducted on January 26, 2016, and identified no new studies.

Study Selection

Two reviewers independently reviewed all identified titles and abstracts and then relevant full-text articles against prespecified inclusion and exclusion criteria (see eTable 1 in the systematic review supplement). Discrepancies were resolved through discussion and consensus. Fair- and good-quality randomized clinical trials (RCTs) and before-and-after studies with concurrent controls among mothers of full- or near-term infants, as well as members of the mother-infant support system (e.g., partners, grandparents, or friends), were eligible. Included studies targeted the effects of prenatal, peripartum, or postpartum breastfeeding interventions initiated in, feasible for, or referable from primary care settings. Infant health outcomes included, but were not limited to, gastrointestinal illness, otitis media, respiratory illness, asthma, atopic dermatitis, and infant health care utilization (as a proxy for health outcomes). Maternal health outcomes included those such as postpartum weight loss and incidence of breast cancer. Breastfeeding outcomes included self-reported or observed initiation of breastfeeding, or the prevalence and duration of any or exclusive breastfeeding. For adverse events, harms that could be related to a breastfeeding intervention (e.g., feeling criticized by the interventionist, guilt related to not starting breastfeeding or stopping breastfeeding) were included; harms related to breastfeeding itself (e.g., mastitis, nipple pain) were excluded. Studies were required to take place in developed countries, defined as "very high" (>0.9) on the 2014 United Nations Human Development Index to ensure that the evidence was applicable to a U.S. setting.

Number of Source Documents

See the literature flow diagram (Figure 2) in the systematic review (see the "Availability of Companion Documents" field) for a summary of evidence search and selection.

Articles included for Key Questions:

- Key Question 1: 7 articles (6 studies)
- Key Question 2: 57 articles (52 studies)
- Key Question 3: 2 articles (2 studies)

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Two reviewers independently assessed the methodological quality of all eligible studies, including the original studies, using the U.S. Preventive Services Task Force (USPSTF) study design–specific criteria (see eTable 2 in the systematic review supplement [see the "Availability of Companion Documents" field]). Each study was assigned a final quality rating of good, fair, or poor; disagreements between the investigators were resolved through discussion.

Methods Used to Analyze the Evidence

Meta-Analysis

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Kaiser Permanente Research Affiliates Evidence-Based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Extraction and Quality Assessment

Two reviewers independently assessed the methodological quality of all eligible studies, including the original studies, using the USPSTF study design–specific criteria (see eTable 2 in the systematic review supplement). Each study was assigned a final quality rating of good, fair, or poor; disagreements between the investigators were resolved through discussion. Studies were rated as poor quality and excluded if there were several major risks of bias (e.g., evidence of selection bias or confounding, attrition greater than 40%, differential attrition higher than 20% and not accounting for missing data, inadequate assessor blinding) that could invalidate the results. One reviewer completed primary data abstraction, and a second reviewer checked all data for accuracy and completeness.

Data Synthesis and Analysis

Summary tables were created for study characteristics, population characteristics, intervention characteristics, and outcomes separately for each key question (KQ). The data on health outcomes (KQ1) and adverse events (KQ3) did not allow for pooled analyses and so were summarized descriptively. For breastfeeding outcomes (KQ2), the results of studies among adolescents or young adults (i.e., women 21 years or younger) and those among adults were synthesized separately. The results for adults were organized by the level of intervention (individual vs. system) and, owing to the clinical heterogeneity between them, were not pooled across these intervention types. Individual level interventions included individual or group counseling provided by professionals, peer support, and structured education, whereas system-level interventions included hospital staff training and hospital policies (e.g., the Baby-friendly Hospital Initiative [BFHI]). Because of the small number of studies available for system-level interventions, those results are reported narratively and without pooling the data.

For individual-level interventions with breastfeeding outcomes, the raw number of events (prevalence of breastfeeding initiation, any breastfeeding, or exclusive breastfeeding) in each treatment group and the total number of participants randomized for each group were entered into random-effects meta-analyses using the Der Simonian and Laird method to calculate a pooled risk ratio (RR) (with the RR indicating the risk of still breastfeeding). The breastfeeding results were grouped into 5 distinct cross-sectional time points to correspond with U.S. Healthy People 2020 objectives: breastfeeding initiation (at birth up through 1 week postpartum) and breastfeeding less than 3 months (2 through 11 weeks), 3 to less than 6 months (12 through 23 weeks), 6 months (24 through 26 weeks), and 12 months (52 weeks). Each study could be included within more than 1 meta-analysis if it reported corresponding data. Within each study, however, the data from the longest time point within a given time category was chosen if more than 1 time point was reported (e.g., if a study reported both 12- and 20-week outcomes, the 20-week results were pooled); with this approach, an individual trial never contributed to more than 1 data point for a given pooled estimate. The specific definition of breastfeeding initiation, any breastfeeding, and exclusive breastfeeding was noted as described by each individual study.

Statistical heterogeneity among the pooled studies was examined using standard X^2 tests, and the proportion of total variability in point estimates was approximated using the I^2 statistic. Sensitivity analyses using a restricted maximum-likelihood model with the Knapp-Hartung modification were run for all meta-analyses that resulted in substantial heterogeneity (I^2 >50%). All statistically significant results remained within the restricted maximum likelihood model, so the results using the DerSimonian and Laird method are shown. To evaluate small-study effects, funnel plots were

generated and the Peters test was run to assess statistical significance of imbalance in study size and findings that suggested a pattern.

Visual displays were first used to investigate whether the heterogeneity among the results was associated with any prespecified population or intervention characteristics; then, where indicated, meta-regression and subgroup analyses were used.

Stata version 13.1 (Stata Corp) was used for all quantitative analyses. All significance testing was 2-sided, and results were considered statistically significant if the P value was .05 or less.

Methods Used to Formulate the Recommendations

Balance Sheets

Expert Consensus

Description of Methods Used to Formulate the Recommendations

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

U.S. Preventive Services Task Force Recommendation Grid*

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	**Moderate**	**Small**	**Zero/Negative**
High	A	B	C	D
Moderate	B	B	C	D
Low	Insufficient			

**A*, *B*, *C*, *D*, and *I (Insufficient)* represent the letter grades of recommendation or statement of insufficient evidence assigned by the USPSTF after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the USPSTF seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the USPSTF considers indirect evidence. To guide its selection of indirect evidence, the Task Force constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)
3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist the USPSTF in drawing conclusions (e.g., presence or absence of dose-response effects, fit within a biologic model)?

The next step in the USPSTF process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the USPSTF's overall assessment of evidence was described as good, fair, or poor. The USPSTF

realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term *certainty* will now be used to describe the USPSTF's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the USPSTF makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The USPSTF must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that one of the key questions in the analytic framework refers to the potential harms of the preventive service. The USPSTF considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the USPSTF assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The USPSTF would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The USPSTF would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty. Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see the "Availability of Companion Documents" field) summarizes the current terminology used by the USPSTF to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF, Guirguis-Blake J, LeFevre M, Harris R, Petitti D; U.S. Preventive Services Task Force. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875. [5 references].

Rating Scheme for the Strength of the Recommendations

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
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C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read the "Clinical Considerations" section of the USPSTF Recommendation Statement (see the "Major Recommendations" field). If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

Cost Analysis

The U.S. Preventive Services Task Force (USPSTF) does not consider the costs of providing a service in this assessment.

Method of Guideline Validation

Comparison with Guidelines from Other Groups

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Peer Review

Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center (EPC) and the Agency for Healthcare Research and Quality (AHRQ) send the draft evidence review to 4 to 6 external experts and to Federal agencies and professional and disease-based health organizations with interests in the topic. The experts are asked to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. The draft evidence review is also posted on the USPSTF Web site for public comment. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the USPSTF in memo form. In this way, the USPSTF can consider these external comments before it votes on its recommendations about the service. Draft recommendation statements are then circulated for comment among reviewers representing professional societies, voluntary organizations, and Federal agencies, as well as posted on the USPSTF Web site for public comment. These comments are discussed before the final recommendations are confirmed.

Response to Public Comment

A draft version of this recommendation statement was posted for public comment on the USPSTF Web site from April 26 to May 23, 2016. Many comments expressed concern that the recommendation did not explicitly include the term "promotion" of breastfeeding. The USPSTF interprets support as including promotion. The USPSTF revised the recommendation statement to clarify that it has not changed its confidence in the benefits of breastfeeding and that it continues to recommend interventions to encourage breastfeeding. The USPSTF also clarified that there has been no change from the previous recommendation in the type of interventions being recommended. Other comments expressed concern that the recommendation would lead to undue pressure on women who decide not to breastfeed. The USPSTF reviewed the language in the recommendation to ensure that the autonomy of women is respected. Comments also requested that the USPSTF address policy- and society-level barriers to breastfeeding; although these are indeed important issues, they are beyond the scope of the USPSTF.

Comparison with Guidelines from Other Groups

Recommendations for primary care interventions from the following groups were discussed: the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the World Health Organization (WHO)/United Nations Children's Fund (UNICEF), the American Academy of Family Physicians, the National Association of Pediatric Nurse Practitioners, and the U.S. Surgeon General.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendation is not specifically stated.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Effectiveness of Interventions to Change Behavior

Adequate evidence indicates that interventions to support breastfeeding increase the duration and rates of breastfeeding, including exclusive breastfeeding.

Potential Harms

Harms of Interventions to Change Behavior

There is adequate evidence to bound the potential harms of interventions to support breastfeeding are no greater than small, based on the nature of the intervention, the low likelihood of serious harms, and the available information from studies reporting few harms.

Contraindications

Contraindications

This recommendation does not apply to circumstances in which there are contraindications to breastfeeding (e.g., certain maternal medical conditions or infant metabolic disorders, such as galactosemia).

Qualifying Statements

Qualifying Statements

Qualifying Statements

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific clinical preventive services for patients without obvious related signs or symptoms.
- It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.
- The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.
- Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality (AHRQ) or the U.S. Department of Health and Human Services.

Implementation of the Guideline

Description of Implementation Strategy

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the USPSTF will make all its products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access USPSTF materials and adapt them for their local needs. Online access to USPSTF products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

Implementation Tools

Mobile Device Resources

Patient Resources

Pocket Guide/Reference Cards

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

U.S. Preventive Services Task Force. Primary care interventions to support breastfeeding: U.S. Preventive Services Task Force Recommendation Statement. JAMA. 2016 Oct 25;316(16):1688-93. [19 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2016 Oct 25

Guideline Developer(s)

U.S. Preventive Services Task Force - Independent Expert Panel

Guideline Developer Comment

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

Source(s) of Funding

The U.S. Preventive Services Task Force (USPSTF) is an independent, voluntary body. The U.S. Congress mandates that the Agency for Healthcare Research and Quality (AHRQ) support the operations of the USPSTF.

Guideline Committee

U.S. Preventive Services Task Force (USPSTF)

Composition of Group That Authored the Guideline

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*Members of the USPSTF at the time this recommendation was finalized. For a list of current Task Force members, go to http://www.uspreventiveservicestaskforce.org/Page/Name/our-members.

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Conflict of Interest Disclosures

All authors have completed and submitted the International Committee of Medical Journal Editors (ICMJE) Form for Disclosure of Potential Conflicts of Interest and none were reported. Authors followed the policy regarding conflicts of interest described at http://www.uspreventiveservicestaskforce.org/Page/Name/conflict-of-interest-disclosures. All members of the USPSTF receive travel reimbursement and an honorarium for participating in USPSTF meetings.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force. Primary care interventions to promote breastfeeding: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med. 2008 Oct 21;149(8):560-4. [11 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the Journal of the American Medical Association (JAMA) Web site.

Availability of Companion Documents

The following are available:

Evidence Reviews:

- Patnode CD, Henniger ML, Senger CA, Perdue LA, Whitlock EP. Primary care interventions to support breastfeeding: updated systematic review for the U.S. Preventive Services Task Force. Evidence Synthesis No. 143. AHRQ Publication No. 15-05218-EF-1. Rockville (MD): Agency for Healthcare Research and Quality; 2016 Oct. 150 p.
- Patnode CD, Henniger ML, Senger CA, Perdue LA, Whitlock EP. Primary care interventions to support breastfeeding: updated evidence report and systematic review for the U.S. Preventive Services Task Force. JAMA. 2016 Oct 25; 316(16):1694-1705.

Available from the U.S Preventive Services Task Force (USPSTF) Web site.

Background Articles:

- Barton M et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. Ann Intern Med. 2007;147:123-7.
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. Ann Intern Med. 2007;147:117-22. [2 references]
- Sawaya GF et al., Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-5. [5 references].

Available from USPSTF Web site.

The following are also available:

- Primary care interventions to support breastfeeding: clinical summary. Rockville (MD): Agency for Healthcare Research and Quality; 2016 Oct. 1 p. Available from the USPSTF Web site.
- A continuing medical education (CME) activity is available free with registration from the Journal of the American Medical Association (JAMA) Web site.

The Electronic Preventive Services Selector (ePSS) is an application designed to provide primary care clinicians and health care teams timely decision support regarding appropriate screening, counseling, and preventive services for their patients. It is based on the current, evidence-based recommendations of the USPSTF and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors.

Patient Resources

The following is available:

- Interventions to support breastfeeding. JAMA patient page. JAMA. 2016 Oct 25;316(16):1726. Available from the Journal of the American Medical Association (JAMA) Web site.

Myhealthfinder is a tool that provides personalized recommendations for clinical preventive services specific to the user's age, gender, and pregnancy status. It features evidence-based recommendations from the USPSTF and is available at www.healthfinder.gov.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

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